

<i>(For Safety Staff only)</i>	REPORT NO.	EROC CODE	<b>UNITED STATES ARMY CORPS OF ENGINEERS ACCIDENT INVESTIGATION REPORT</b> <i>(For Use of this Form See Help Menu and USACE Suppl to AR 385-40)</i>				REQUIREMENT CONTROL SYMBOL: CEEC-S-8(R2)		
<b>1. ACCIDENT CLASSIFICATION</b>									
PERSONNEL CLASSIFICATION		INJURY/ILLNESS/FATAL		PROPERTY DAMAGE		MOTOR VEHICLE INVOLVED			
GOVERNMENT <input type="checkbox"/> CIVILIAN <input type="checkbox"/> MILITARY		<input type="checkbox"/>		<input type="checkbox"/> FIRE INVOLVED <input type="checkbox"/> OTHER		<input type="checkbox"/>			
<input type="checkbox"/> CONTRACTOR		<input type="checkbox"/>		<input type="checkbox"/> FIRE INVOLVED <input type="checkbox"/> OTHER		<input type="checkbox"/>			
<input type="checkbox"/> PUBLIC		<input type="checkbox"/> FATAL <input type="checkbox"/> OTHER		<del>PROPERTY DAMAGE</del>		<del>MOTOR VEHICLE INVOLVED</del>			
<b>2. PERSONAL DATA</b>									
a. Name <i>(Last, First, MI)</i>		b. AGE	c. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		d. SOCIAL SECURITY NUMBER				
e. GRADE		f. JOB SERIES/TITLE		g. DUTY STATUS AT TIME OF ACCIDENT <input type="checkbox"/> ON DUTY <input type="checkbox"/> TDY  <input type="checkbox"/> OFF DUTY					
h. EMPLOYMENT STATUS AT TIME OF ACCIDENT <input type="checkbox"/> ARMY ACTIVE <input type="checkbox"/> ARMY RESERVE <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> PERMANENT <input type="checkbox"/> FOREIGN NATIONAL <input type="checkbox"/> SEASONAL <input type="checkbox"/> TEMPORARY <input type="checkbox"/> STUDENT <input type="checkbox"/> OTHER <i>(Specify)</i> _____									
<b>3. GENERAL INFORMATION</b>									
a. DATE OF ACCIDENT <i>(month/day/year)</i>		b. TIME OF ACCIDENT <i>(Military time)</i> hrs		c. EXACT LOCATION OF ACCIDENT		d. CONTRACTOR'S NAME			
e. CONTRACT NUMBER _____		f. TYPE OF CONTRACT <input type="checkbox"/> CONSTRUCTION <input type="checkbox"/> SERVICE <input type="checkbox"/> A/E <input type="checkbox"/> DREDGE <input type="checkbox"/> OTHER <i>(Specify)</i> _____		g. HAZARDOUS/TOXIC WASTE ACTIVITY <input type="checkbox"/> SUPERFUND <input type="checkbox"/> DERP <input type="checkbox"/> IRP <input type="checkbox"/> OTHER <i>(Specify)</i> _____		(1) PRIME:  (2) SUBCONTRACTOR:			
<b>4. CONSTRUCTION ACTIVITIES ONLY</b> <i>(Fill in line and corresponding code number in box from list - see help menu)</i>									
a. CONSTRUCTION ACTIVITY _____ (CODE) # <input type="text"/>				b. TYPE OF CONSTRUCTION EQUIPMENT _____ (CODE) # <input type="text"/>					
<b>5. INJURY/ILLNESS INFORMATION</b> <i>(Include name on line and corresponding code number in box for items e, f &amp; g - see help menu)</i>									
a. SEVERITY OF ILLNESS/INJURY _____ (CODE) # <input type="text"/>				b. ESTIMATED DAYS LOST	c. ESTIMATED DAYS HOSPITALIZED	d. ESTIMATED DAYS RESTRICTED DUTY			
e. BODY PART AFFECTED PRIMARY _____ (CODE) # <input type="text"/> SECONDARY _____ (CODE) # <input type="text"/>				g. TYPE AND SOURCE OF INJURY/ILLNESS TYPE _____ (CODE) # <input type="text"/> SOURCE _____ (CODE) # <input type="text"/>					
f. NATURE OF ILLNESS/INJURY _____ (CODE) # <input type="text"/>									
<b>6. PUBLIC FATALITY</b> <i>(Fill in line and correspondence code number in box - see help menu)</i>									
a. ACTIVITY AT TIME OF ACCIDENT _____ (CODE) # <input type="text"/>				b. PERSONAL FLOATATION DEVICE USED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A					
<b>7. MOTOR VEHICLE ACCIDENT</b>									
a. TYPE OF VEHICLE <input type="checkbox"/> PICKUP/VAN <input type="checkbox"/> AUTOMOBILE <input type="checkbox"/> TRUCK <input type="checkbox"/> OTHER <i>(Specify)</i> _____		b. TYPE OF COLLISION <input type="checkbox"/> SIDE SWIPE <input type="checkbox"/> HEAD ON <input type="checkbox"/> REAR END <input type="checkbox"/> BROADSIDE <input type="checkbox"/> ROLL OVER <input type="checkbox"/> BACKING <input type="checkbox"/> OTHER <i>(Specify)</i> _____			c. SEAT BELTS		USED	NOT USED	NOT AVAILABLE
					(1) FRONT SEAT				
					(2) REAR SEAT				
<b>8. PROPERTY/MATERIAL INVOLVED</b>									
a. NAME OF ITEM			b. OWNERSHIP		c. \$ AMOUNT OF DAMAGE				
(1)									
(2)									
(3)									
<b>9. VESSEL/FLOATING PLANT ACCIDENT</b> <i>(Fill in line and correspondence code number in box from list - see help menu)</i>									
a. TYPE OF VESSEL/FLOATING PLANT _____ (CODE) # <input type="text"/>				b. TYPE OF COLLISION/MISHAP _____ (CODE) # <input type="text"/>					
<b>10. ACCIDENT DESCRIPTION</b> <i>(Use additional paper, if necessary)</i>									

<b>11. CAUSAL FACTOR(S) (Read Instruction Before Completing)</b>					
<p>a. (Explain YES answers in item 13)</p> <p>DESIGN: Was design of facility, workplace or equipment a factor? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>INSPECTION/MAINTENANCE: Were inspection &amp; maintenance procedures a factor? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PERSON'S PHYSICAL CONDITION: In your opinion, was the physical condition of the person a factor? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>OPERATING PROCEDURES: Were operating procedures a factor? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>JOB PRACTICES: Were any job safety/health practices not followed when the accident occurred? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HUMAN FACTORS: Did any human factors such as, size or strength of person, etc., contribute to accident? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ENVIRONMENTAL FACTORS: Did heat, cold, dust, sun, glare, etc., contribute to the accident? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>			<p>a. (CONTINUED)</p> <p>CHEMICAL AND PHYSICAL AGENT FACTORS: Did exposure to chemical agents, such as dust, fumes, mists, vapors or physical agents, such as, noise, radiation, etc., contribute to accident? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>OFFICE FACTORS: Did office setting such as, lifting office furniture, carrying, stooping, etc., contribute to the accident? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>SUPPORT FACTORS: Were inappropriate tools/resources provided to properly perform the activity/task? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PERSONAL PROTECTIVE EQUIPMENT: Did the improper selection, use or maintenance of personal protective equipment contribute to the accident? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DRUGS/ALCOHOL: In your opinion, was drugs or alcohol a factor to the accident? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		
			<p>b. WAS A WRITTEN JOB/ACTIVITY HAZARD ANALYSIS COMPLETED FOR TASK BEING PERFORMED AT TIME OF ACCIDENT?</p> <p><input type="checkbox"/> YES (If yes, attach a copy.) <input type="checkbox"/> NO</p>		

<b>12. TRAINING</b>		
<p>a. WAS PERSON TRAINED TO PERFORM ACTIVITY/TASK?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>b. TYPE OF TRAINING.</p> <p><input type="checkbox"/> CLASSROOM <input type="checkbox"/> ON JOB</p>	<p>c. DATE OF MOST RECENT FORMAL TRAINING.</p> <p>(Month) (Day) (Year)</p>

<b>13. FULLY EXPLAIN WHAT ALLOWED OR CAUSED THE ACCIDENT; INCLUDE DIRECT AND INDIRECT CAUSES (See instruction for definition of direct and indirect causes.) (Use additional paper, if necessary)</b>	
a. DIRECT CAUSE	
b. INDIRECT CAUSE(S)	

<b>14. ACTION(S) TAKEN, ANTICIPATED OR RECOMMENDED TO ELIMINATE CAUSE(S).</b>	
DESCRIBE FULLY:	

<b>15. DATES FOR ACTIONS IDENTIFIED IN BLOCK 14.</b>					
a. BEGINNING (Month/Day/Year)			b. ANTICIPATED COMPLETION (Month/Day/Year)		
c. SIGNATURE AND TITLE OF SUPERVISOR COMPLETING REPORT		d. DATE (Mo/Da/Yr)	e. ORGANIZATION IDENTIFIER (Div, Br, Sect)	f. OFFICE SYMBOL	
CORPS _____					
CONTRACTOR _____					

<b>16. MANAGEMENT REVIEW (1st)</b>		
a. <input type="checkbox"/> CONCUR b. <input type="checkbox"/> NON CONCUR c. COMMENTS		
SIGNATURE	TITLE	DATE

<b>17. MANAGEMENT REVIEW (2nd - Chief Operations, Construction, Engineering, etc.)</b>		
a. <input type="checkbox"/> CONCUR b. <input type="checkbox"/> NON CONCUR c. COMMENTS		
SIGNATURE	TITLE	DATE

<b>18. SAFETY AND OCCUPATIONAL HEALTH OFFICE REVIEW</b>		
a. <input type="checkbox"/> CONCUR b. <input type="checkbox"/> NON CONCUR c. ADDITIONAL ACTIONS/COMMENTS		
SIGNATURE	TITLE	DATE

<b>19. COMMAND APPROVAL</b>	
COMMENTS	
COMMANDER SIGNATURE	DATE

**10. ACCIDENT DESCRIPTION (Continuation)**

**13a. DIRECT CAUSE (Continuation)**

13b.

**INDIRECT CAUSES** *(Continuation)*

14.

**ACTION(S) TAKEN, ANTICIPATED, OR RECOMMENDED TO ELIMINATE CAUSE(S)** *(Continuation)*